

REFERENCE TITLE: medically prescribed foods; disorders; allergies

State of Arizona  
House of Representatives  
Forty-seventh Legislature  
Second Regular Session  
2006

## HB 2364

Introduced by  
Representatives Huffman, Hershberger, Lopez L, O'Halleran: Lopes

AN ACT

AMENDING SECTIONS 20-826, 20-1057, 20-1342, 20-1402, 20-1404 AND 20-2327,  
ARIZONA REVISED STATUTES; RELATING TO INSURANCE CONTRACTS AND POLICIES.

(TEXT OF BILL BEGINS ON NEXT PAGE)

1 Be it enacted by the Legislature of the State of Arizona:

2 Section 1. Section 20-826, Arizona Revised Statutes, is amended to  
3 read:

4 20-826. Subscription contracts: definitions

5 A. A contract between a corporation and its subscribers shall not be  
6 issued unless the form of such contract is approved in writing by the  
7 director.

8 B. Each contract shall plainly state the services to which the  
9 subscriber is entitled and those to which the subscriber is not entitled  
10 under the plan, and shall constitute a direct obligation of the providers of  
11 services with which the corporation has contracted for hospital, medical,  
12 dental or optometric services.

13 C. Each contract, except for dental services or optometric services,  
14 shall be so written that the corporation shall pay benefits for each of the  
15 following:

16 1. Performance of any surgical service that is covered by the terms of  
17 such contract, regardless of the place of service.

18 2. Any home health services that are performed by a licensed home  
19 health agency and that a physician has prescribed in lieu of hospital  
20 services, as defined by the director, providing the hospital services would  
21 have been covered.

22 3. Any diagnostic service that a physician has performed outside a  
23 hospital in lieu of inpatient service, providing the inpatient service would  
24 have been covered.

25 4. Any service performed in a hospital's outpatient department or in a  
26 freestanding surgical facility, if such service would have been covered if  
27 performed as an inpatient service.

28 D. Each contract for dental or optometric services shall be so written  
29 that the corporation shall pay benefits for contracted dental or optometric  
30 services provided by dentists or optometrists.

31 E. Any contract, except accidental death and dismemberment, applied  
32 for that provides family coverage shall **ALSO PROVIDE**, as to such coverage of  
33 family members, ~~also provide~~ that the benefits applicable for children shall  
34 be payable with respect to a newly born child of the insured from the instant  
35 of such child's birth, to a child adopted by the insured, regardless of the  
36 age at which the child was adopted, and to a child who has been placed for  
37 adoption with the insured and for whom the application and approval  
38 procedures for adoption pursuant to section 8-105 or 8-108 have been  
39 completed to the same extent that such coverage applies to other members of  
40 the family. The coverage for newly born or adopted children or children  
41 placed for adoption shall include coverage of injury or sickness including  
42 necessary care and treatment of medically diagnosed congenital defects and  
43 birth abnormalities. If payment of a specific premium is required to provide  
44 coverage for a child, the contract may require that notification of birth,  
45 adoption or adoption placement of the child and payment of the required

1 premium must be furnished to the insurer within thirty-one days after the  
2 date of birth, adoption or adoption placement in order to have the coverage  
3 continue beyond the thirty-one day period.

4 F. Each contract that is delivered or issued for delivery in this  
5 state after December 25, 1977 and that provides that coverage of a dependent  
6 child shall terminate upon attainment of the limiting age for dependent  
7 children specified in the contract shall also provide in substance that  
8 attainment of such limiting age shall not operate to terminate the coverage  
9 of such child while the child is and continues to be both incapable of  
10 self-sustaining employment by reason of mental retardation or physical  
11 handicap and chiefly dependent upon the subscriber for support and  
12 maintenance. Proof of such incapacity and dependency shall be furnished to  
13 the corporation by the subscriber within thirty-one days of the child's  
14 attainment of the limiting age and subsequently as may be required by the  
15 corporation, but not more frequently than annually after the two-year period  
16 following the child's attainment of the limiting age.

17 G. No corporation may cancel or refuse to renew any subscriber's  
18 contract without giving notice of such cancellation or nonrenewal to the  
19 subscriber under such contract. A notice by the corporation to the  
20 subscriber of cancellation or nonrenewal of a subscription contract shall be  
21 mailed to the named subscriber at least forty-five days before the effective  
22 date of such cancellation or nonrenewal. The notice shall include or be  
23 accompanied by a statement in writing of the reasons for such action by the  
24 corporation. Failure of the corporation to comply with ~~the provisions of~~  
25 this subsection shall invalidate any cancellation or nonrenewal except a  
26 cancellation or nonrenewal for nonpayment of premium.

27 H. A contract that provides coverage for surgical services for a  
28 mastectomy shall also provide coverage incidental to the patient's covered  
29 mastectomy for surgical services for reconstruction of the breast on which  
30 the mastectomy was performed, surgery and reconstruction of the other breast  
31 to produce a symmetrical appearance, prostheses, treatment of physical  
32 complications for all stages of the mastectomy, including lymphedemas, and at  
33 least two external postoperative prostheses subject to all of the terms and  
34 conditions of the policy.

35 I. A contract that provides coverage for surgical services for a  
36 mastectomy shall also provide coverage for mammography screening performed on  
37 dedicated equipment for diagnostic purposes on referral by a patient's  
38 physician, subject to all of the terms and conditions of the policy and  
39 according to the following guidelines:

40 1. A baseline mammogram for a woman from age thirty-five to  
41 thirty-nine.

42 2. A mammogram for a woman from age forty to forty-nine every two  
43 years or more frequently based on the recommendation of the woman's  
44 physician.

45 3. A mammogram every year for a woman fifty years of age and over.

J. Any contract that is issued to the insured and that provides coverage for maternity benefits shall also provide that the maternity benefits apply to the costs of the birth of any child legally adopted by the insured if all of the following are true:

1. The child is adopted within one year of birth.
2. The insured is legally obligated to pay the costs of birth.
3. All preexisting conditions and other limitations have been met by the insured.

4. The insured has notified the insurer of the insured's acceptability to adopt children pursuant to section 8-105, within sixty days after such approval or within sixty days after a change in insurance policies, plans or companies.

K. The coverage prescribed by subsection J of this section is excess to any other coverage the natural mother may have for maternity benefits except coverage made available to persons pursuant to title 36, chapter 29 but not including coverage made available to persons defined as eligible under section 36-2901, paragraph 6, subdivisions (b), (c), (d) and (e). If such other coverage exists the agency, attorney or individual arranging the adoption shall make arrangements for the insurance to pay those costs that may be covered under that policy and shall advise the adopting parent in writing of the existence and extent of the coverage without disclosing any confidential information such as the identity of the natural parent. The insured adopting parents shall notify their insurer of the existence and extent of the other coverage.

L. The director may disapprove any contract if the benefits provided in the form of such contract are unreasonable in relation to the premium charged.

M. The director shall adopt emergency rules applicable to persons who are leaving active service in the armed forces of the United States and returning to civilian status including:

1. Conditions of eligibility.
2. Coverage of dependents.
3. Preexisting conditions.
4. Termination of insurance.
5. Probationary periods.
6. Limitations.
7. Exceptions.
8. Reductions.
9. Elimination periods.
10. Requirements for replacement.
11. Any other condition of subscription contracts.

N. Any contract that provides maternity benefits shall not restrict benefits for any hospital length of stay in connection with childbirth for the mother or the newborn child to less than forty-eight hours following a normal vaginal delivery or ninety-six hours following a cesarean section.

The contract shall not require the provider to obtain authorization from the corporation for prescribing the minimum length of stay required by this subsection. The contract may provide that an attending provider in consultation with the mother may discharge the mother or the newborn child before the expiration of the minimum length of stay required by this subsection. The corporation shall not:

1. Deny the mother or the newborn child eligibility or continued eligibility to enroll or to renew coverage under the terms of the contract solely for the purpose of avoiding the requirements of this subsection.

2. Provide monetary payments or rebates to mothers to encourage those mothers to accept less than the minimum protections available pursuant to this subsection.

3. Penalize or otherwise reduce or limit the reimbursement of an attending provider because that provider provided care to any insured under the contract in accordance with this subsection.

4. Provide monetary or other incentives to an attending provider to induce that provider to provide care to an insured under the contract in a manner that is inconsistent with this subsection.

5. Except as described in subsection O of this section, restrict benefits for any portion of a period within the minimum length of stay in a manner that is less favorable than the benefits provided for any preceding portion of that stay.

O. Nothing in subsection N of this section:

1. Requires a mother to give birth in a hospital or to stay in the hospital for a fixed period of time following the birth of the child.

2. Prevents a corporation from imposing deductibles, coinsurance or other cost sharing in relation to benefits for hospital lengths of stay in connection with childbirth for a mother or a newborn child under the contract, except that any coinsurance or other cost sharing for any portion of a period within a hospital length of stay required pursuant to subsection N of this section shall not be greater than the coinsurance or cost sharing for any preceding portion of that stay.

3. Prevents a corporation from negotiating the level and type of reimbursement with a provider for care provided in accordance with subsection N of this section.

P. Any contract that provides coverage for diabetes shall also provide coverage for equipment and supplies that are medically necessary and that are prescribed by a health care provider including:

1. Blood glucose monitors.

2. Blood glucose monitors for the legally blind.

3. Test strips for glucose monitors and visual reading and urine testing strips.

4. Insulin preparations and glucagon.

5. Insulin cartridges.

6. Drawing up devices and monitors for the visually impaired.

1           7. Injection aids.  
2           8. Insulin cartridges for the legally blind.  
3           9. Syringes and lancets including automatic lancing devices.  
4           10. Prescribed oral agents for controlling blood sugar that are  
5 included on the plan formulary.  
6           11. To the extent coverage is required under medicare, podiatric  
7 appliances for prevention of complications associated with diabetes.  
8           12. Any other device, medication, equipment or supply for which  
9 coverage is required under medicare from and after January 1, 1999. The  
10 coverage required in this paragraph is effective six months after the  
11 coverage is required under medicare.  
12           Q. Nothing in subsection P of this section prohibits a medical service  
13 corporation, a hospital service corporation or a hospital, medical, dental  
14 and optometric service corporation from imposing deductibles, coinsurance or  
15 other cost sharing in relation to benefits for equipment or supplies for the  
16 treatment of diabetes.  
17           R. Any hospital or medical service contract that provides coverage for  
18 prescription drugs shall not limit or exclude coverage for any prescription  
19 drug prescribed for the treatment of cancer on the basis that the  
20 prescription drug has not been approved by the United States food and drug  
21 administration for the treatment of the specific type of cancer for which the  
22 prescription drug has been prescribed, if the prescription drug has been  
23 recognized as safe and effective for treatment of that specific type of  
24 cancer in one or more of the standard medical reference compendia prescribed  
25 in subsection S of this section or medical literature that meets the criteria  
26 prescribed in subsection S of this section. The coverage required under this  
27 subsection includes covered medically necessary services associated with the  
28 administration of the prescription drug. This subsection does not:  
29           1. Require coverage of any prescription drug used in the treatment of  
30 a type of cancer if the United States food and drug administration has  
31 determined that the prescription drug is contraindicated for that type of  
32 cancer.  
33           2. Require coverage for any experimental prescription drug that is not  
34 approved for any indication by the United States food and drug  
35 administration.  
36           3. Alter any law with regard to provisions that limit the coverage of  
37 prescription drugs that have not been approved by the United States food and  
38 drug administration.  
39           4. Notwithstanding section 20-841.05, require reimbursement or  
40 coverage for any prescription drug that is not included in the drug formulary  
41 or list of covered prescription drugs specified in the contract.  
42           5. Notwithstanding section 20-841.05, prohibit a contract from  
43 limiting or excluding coverage of a prescription drug, if the decision to  
44 limit or exclude coverage of the prescription drug is not based primarily on  
45 the coverage of prescription drugs required by this section.

1           6. Prohibit the use of deductibles, coinsurance, copayments or other  
2 cost sharing in relation to drug benefits and related medical benefits  
3 offered.

4           S. For the purposes of subsection R of this section:

5           1. The acceptable standard medical reference compendia are the  
6 following:

7           (a) The American medical association drug evaluations, a publication  
8 of the American medical association.

9           (b) The American hospital formulary service drug information, a  
10 publication of the American society of health system pharmacists.

11           (c) Drug information for the health care provider, a publication of  
12 the United States pharmacopoeia convention.

13           2. Medical literature may be accepted if all of the following apply:

14           (a) At least two articles from major peer reviewed professional  
15 medical journals have recognized, based on scientific or medical criteria,  
16 the drug's safety and effectiveness for treatment of the indication for which  
17 the drug has been prescribed.

18           (b) No article from a major peer reviewed professional medical journal  
19 has concluded, based on scientific or medical criteria, that the drug is  
20 unsafe or ineffective or that the drug's safety and effectiveness cannot be  
21 determined for the treatment of the indication for which the drug has been  
22 prescribed.

23           (c) The literature meets the uniform requirements for manuscripts  
24 submitted to biomedical journals established by the international committee  
25 of medical journal editors or is published in a journal specified by the  
26 United States department of health and human services as acceptable peer  
27 reviewed medical literature pursuant to section 186(t)(2)(B) of the social  
28 security act (42 United States Code section 1395x(t)(2)(B)).

29           T. A corporation shall not issue or deliver any advertising matter or  
30 sales material to any person in this state until the corporation files the  
31 advertising matter or sales material with the director. This subsection does  
32 not require a corporation to have the prior approval of the director to issue  
33 or deliver the advertising matter or sales material. If the director finds  
34 that the advertising matter or sales material, in whole or in part, is false,  
35 deceptive or misleading, the director may issue an order disapproving the  
36 advertising matter or sales material, directing the corporation to cease and  
37 desist from issuing, circulating, displaying or using the advertising matter  
38 or sales material within a period of time specified by the director but not  
39 less than ten days and imposing any penalties prescribed in this title. At  
40 least five days before issuing an order pursuant to this subsection, the  
41 director shall provide the corporation with a written notice of the basis of  
42 the order to provide the corporation with an opportunity to cure the alleged  
43 deficiency in the advertising matter or sales material within a single five  
44 day period for the particular advertising matter or sales material at issue.  
45 The corporation may appeal the director's order pursuant to title 41, chapter

1 6, article 10. Except as otherwise provided in this subsection, a  
2 corporation may obtain a stay of the effectiveness of the order as prescribed  
3 in section 20-162. If the director certifies in the order and provides a  
4 detailed explanation of the reasons in support of the certification that  
5 continued use of the advertising matter or sales material poses a threat to  
6 the health, safety or welfare of the public, the order may be entered  
7 immediately without opportunity for cure and the effectiveness of the order  
8 is not stayed pending the hearing on the notice of appeal but the hearing  
9 shall be promptly instituted and determined.

10 U. Any contract that is offered by a hospital service corporation or  
11 medical service corporation and that contains a prescription drug benefit  
12 shall provide coverage of medical foods to treat inherited metabolic  
13 disorders OR MEDICALLY DIAGNOSED SEVERE ALLERGIC REACTIONS TO DIETARY  
14 COMPONENTS as provided by this section.

15 V. The metabolic disorders OR ALLERGIC REACTIONS triggering medical  
16 foods coverage under this section shall:

17 1. Be part of the newborn screening program prescribed in section  
18 36-694 OR BE DIAGNOSED SUBSEQUENT TO BIRTH.

19 2. Involve amino acid, carbohydrate or fat metabolism OR SEVERE  
20 ALLERGIC REACTIONS TO DIETARY COMPONENTS.

21 3. Have medically standard methods of diagnosis, treatment and  
22 monitoring including quantification of metabolites in blood, urine or spinal  
23 fluid or enzyme or DNA confirmation in tissues.

24 4. Require specially processed or treated medical foods that are  
25 generally available only under the supervision and direction of a physician  
26 who is licensed pursuant to title 32, chapter 13 or 17, that must be consumed  
27 throughout life and without which the person may suffer serious mental or  
28 physical impairment.

29 W. Medical foods eligible for coverage under this section shall be  
30 prescribed or ordered under the supervision of a physician licensed pursuant  
31 to title 32, chapter 13 or 17 as medically necessary for the therapeutic  
32 treatment of an inherited metabolic disease OR A MEDICALLY DIAGNOSED SEVERE  
33 ALLERGIC REACTION TO DIETARY COMPONENTS.

34 X. A hospital service corporation or medical service corporation shall  
35 cover at least ~~fifty~~ SEVENTY-FIVE per cent of the cost of medical foods  
36 prescribed to treat inherited metabolic disorders OR ALLERGIC REACTIONS and  
37 covered pursuant to this section. A hospital service corporation or medical  
38 service corporation may limit the maximum annual benefit for medical foods  
39 under this section to ~~five~~ TWENTY thousand dollars, which applies to the cost  
40 of all prescribed modified low protein foods and metabolic formula.

41 Y. Any contract between a corporation and its subscribers is subject  
42 to the following:

43 1. If the contract provides coverage for prescription drugs, the  
44 contract shall provide coverage for any prescribed drug or device that is  
45 approved by the United States food and drug administration for use as a



1 contraceptive. A corporation may use a drug formulary, multitiered drug  
 2 formulary or list but that formulary or list shall include oral, implant and  
 3 injectable contraceptive drugs, intrauterine devices and prescription barrier  
 4 methods if the corporation does not impose deductibles, coinsurance,  
 5 copayments or other cost containment measures for contraceptive drugs that  
 6 are greater than the deductibles, coinsurance, copayments or other cost  
 7 containment measures for other drugs on the same level of the formulary or  
 8 list.

9 2. If the contract provides coverage for outpatient health care  
 10 services, the contract shall provide coverage for outpatient contraceptive  
 11 services. For the purposes of this paragraph, "outpatient contraceptive  
 12 services" means consultations, examinations, procedures and medical services  
 13 provided on an outpatient basis and related to the use of **APPROVED** United  
 14 States food and drug **ADMINISTRATION** prescription contraceptive methods to  
 15 prevent unintended pregnancies.

16 3. This subsection does not apply to contracts issued to individuals  
 17 on a nongroup basis.

18 Z. Notwithstanding subsection Y of this section, a religious employer  
 19 whose religious tenets prohibit the use of prescribed contraceptive methods  
 20 may require that the corporation provide a contract without coverage for all  
 21 ~~federal~~ **UNITED STATES** food and drug administration approved contraceptive  
 22 methods. A religious employer shall submit a written affidavit to the  
 23 corporation stating that it is a religious employer. On receipt of the  
 24 affidavit, the corporation shall issue to the religious employer a contract  
 25 that excludes coverage of prescription contraceptive methods. The  
 26 corporation shall retain the affidavit for the duration of the contract and  
 27 any renewals of the contract. Before enrollment in the plan, every religious  
 28 employer that invokes this exemption shall provide prospective subscribers  
 29 written notice that the religious employer refuses to cover all ~~federal~~  
 30 **UNITED STATES** food and drug administration approved contraceptive methods for  
 31 religious reasons. This subsection shall not exclude coverage for  
 32 prescription contraceptive methods ordered by a health care provider with  
 33 prescriptive authority for medical indications other than to prevent an  
 34 unintended pregnancy. A corporation may require the subscriber to first pay  
 35 for the prescription and then submit a claim to the corporation along with  
 36 evidence that the prescription is for a noncontraceptive purpose. A  
 37 corporation may charge an administrative fee for handling these claims. A  
 38 religious employer shall not discriminate against an employee who  
 39 independently chooses to obtain insurance coverage or prescriptions for  
 40 contraceptives from another source.

41 AA. For the purposes of:

42 1. This section:

43 (a) "Inherited metabolic disorder" means a disease caused by an  
 44 inherited abnormality of body chemistry and includes a disease tested under  
 45 the newborn screening program prescribed in section 36-694.

1 (b) "Medical foods" means modified low protein foods and metabolic  
2 formula.

3 (c) "Metabolic formula" means foods that are all of the following:

4 (i) Formulated to be consumed or administered enterally under the  
5 supervision of a physician who is licensed pursuant to title 32, chapter 13  
6 or 17.

7 (ii) Processed or formulated to be deficient in one or more of the  
8 nutrients present in typical foodstuffs.

9 (iii) Administered for the medical and nutritional management of a  
10 person who has limited capacity to metabolize foodstuffs or certain nutrients  
11 contained in the foodstuffs or who has other specific nutrient requirements  
12 as established by medical evaluation.

13 (iv) Essential to a person's optimal growth, health and metabolic  
14 homeostasis.

15 (d) "Modified low protein foods" means foods that are all of the  
16 following:

17 (i) Formulated to be consumed or administered enterally under the  
18 supervision of a physician who is licensed pursuant to title 32, chapter 13  
19 or 17.

20 (ii) Processed or formulated to contain less than one gram of protein  
21 per unit of serving, but does not include a natural food that is naturally  
22 low in protein.

23 (iii) Administered for the medical and nutritional management of a  
24 person who has limited capacity to metabolize foodstuffs or certain nutrients  
25 contained in the foodstuffs or who has other specific nutrient requirements  
26 as established by medical evaluation.

27 (iv) Essential to a person's optimal growth, health and metabolic  
28 homeostasis.

29 2. Subsection E of this section, the term "child", for purposes of  
30 initial coverage of an adopted child or a child placed for adoption but not  
31 for purposes of termination of coverage of such child, means a person under  
32 the age of eighteen years.

33 3. Subsection Z of this section, "religious employer" means an entity  
34 for which all of the following apply:

35 (a) The entity primarily employs persons who share the religious  
36 tenets of the entity.

37 (b) The entity primarily serves persons who share the religious tenets  
38 of the entity.

39 (c) The entity is a nonprofit organization as described in section  
40 6033(a)(2)(A)(i) or (iii) of the internal revenue code of 1986, as amended.

41 Sec. 2. Section 20-1057, Arizona Revised Statutes, is amended to read:

42 20-1057. Evidence of coverage by health care services  
43 organizations; renewability; definitions

44 A. Every enrollee in a health care plan shall be issued an evidence of  
45 coverage by the responsible health care services organization.

1 B. Any contract, except accidental death and dismemberment, applied  
2 for that provides family coverage shall ALSO PROVIDE, as to such coverage of  
3 family members, ~~also provide~~ that the benefits applicable for children shall  
4 be payable with respect to a newly born child of the enrollee from the  
5 instant of such child's birth, to a child adopted by the enrollee, regardless  
6 of the age at which the child was adopted, and to a child who has been placed  
7 for adoption with the enrollee and for whom the application and approval  
8 procedures for adoption pursuant to section 8-105 or 8-108 have been  
9 completed to the same extent that such coverage applies to other members of  
10 the family. The coverage for newly born or adopted children or children  
11 placed for adoption shall include coverage of injury or sickness including  
12 necessary care and treatment of medically diagnosed congenital defects and  
13 birth abnormalities. If payment of a specific premium is required to provide  
14 coverage for a child, the contract may require that notification of birth,  
15 adoption or adoption placement of the child and payment of the required  
16 premium must be furnished to the insurer within thirty-one days after the  
17 date of birth, adoption or adoption placement in order to have the coverage  
18 continue beyond the thirty-one day period.

19 C. Any contract, except accidental death and dismemberment, that  
20 provides coverage for psychiatric, drug abuse or alcoholism services shall  
21 require the health care services organization to provide reimbursement for  
22 ~~such~~ THOSE services in accordance with the terms of the contract without  
23 regard to whether the covered services are rendered in a psychiatric special  
24 hospital or general hospital.

25 D. No evidence of coverage or amendment to the coverage shall be  
26 issued or delivered to any person in this state until a copy of the form of  
27 the evidence of coverage or amendment to the coverage has been filed with and  
28 approved by the director.

29 E. An evidence of coverage shall contain a clear and complete  
30 statement if a contract, or a reasonably complete summary if a certificate of  
31 contract, of:

32 1. The health care services and the insurance or other benefits, if  
33 any, to which the enrollee is entitled under the health care plan.

34 2. Any limitations of the services, kind of services, benefits or kind  
35 of benefits to be provided, including any deductible or copayment feature.

36 3. Where and in what manner information is available as to how  
37 services may be obtained.

38 4. The enrollee's obligation, if any, respecting charges for the  
39 health care plan.

40 F. An evidence of coverage shall not contain provisions or statements  
41 that are unjust, unfair, inequitable, misleading or deceptive, that encourage  
42 misrepresentation or that are untrue.

43 G. The director shall approve any form of evidence of coverage if the  
44 requirements of subsections E and F of this section are met. It is unlawful  
45 to issue such form until approved. If the director does not disapprove any

1 such form within forty-five days after the filing of the form, it is deemed  
2 approved. If the director disapproves a form of evidence of coverage, the  
3 director shall notify the health care services organization. In the notice,  
4 the director shall specify the reasons for the director's disapproval. The  
5 director shall grant a hearing on such disapproval within fifteen days after  
6 a request for a hearing in writing is received from the health care services  
7 organization.

8 H. A health care services organization shall not cancel or refuse to  
9 renew an enrollee's evidence of coverage that was issued on a group basis  
10 without giving notice of the cancellation or nonrenewal to the enrollee and,  
11 on request of the director, to the department of insurance. A notice by the  
12 organization to the enrollee of cancellation or nonrenewal of the enrollee's  
13 evidence of coverage shall be mailed to the enrollee at least sixty days  
14 before the effective date of such cancellation or nonrenewal. The notice  
15 shall include or be accompanied by a statement in writing of the reasons as  
16 stated in the contract for such action by the organization. Failure of the  
17 organization to comply with this subsection shall invalidate any cancellation  
18 or nonrenewal except a cancellation or nonrenewal for nonpayment of premium,  
19 for fraud or misrepresentation in the application or other enrollment  
20 documents or for loss of eligibility as defined in the evidence of coverage.  
21 A health care services organization shall not cancel an enrollee's evidence  
22 of coverage issued on a group basis because of the enrollee's or dependent's  
23 age, except for loss of eligibility as defined in the evidence of coverage,  
24 sex, health status-related factor, national origin or frequency of  
25 utilization of health care services of the enrollee. An evidence of coverage  
26 issued on a group basis shall clearly delineate all terms under which the  
27 health care services organization may cancel or refuse to renew an evidence  
28 of coverage for an enrollee or dependent. Nothing in this subsection  
29 prohibits the cancellation or nonrenewal of a health benefits plan contract  
30 issued on a group basis for any of the reasons allowed in section 20-2309. A  
31 health care services organization may cancel or nonrenew an evidence of  
32 coverage issued to an individual on a nongroup basis only for the reasons  
33 allowed by subsection N of this section.

34 I. A health care plan that provides coverage for surgical services for  
35 a mastectomy shall also provide coverage incidental to the patient's covered  
36 mastectomy for surgical services for reconstruction of the breast on which  
37 the mastectomy was performed, surgery and reconstruction of the other breast  
38 to produce a symmetrical appearance, prostheses, treatment of physical  
39 complications for all stages of the mastectomy, including lymphedemas, and at  
40 least two external postoperative prostheses subject to all of the terms and  
41 conditions of the policy.

42 J. A contract that provides coverage for surgical services for a  
43 mastectomy shall also provide coverage for mammography screening performed on  
44 dedicated equipment for diagnostic purposes on referral by a patient's

1 physician, subject to all of the terms and conditions of the policy and  
2 according to the following guidelines:

3 1. A baseline mammogram for a woman from age thirty-five to  
4 thirty-nine.

5 2. A mammogram for a woman from age forty to forty-nine every two  
6 years or more frequently based on the recommendation of the woman's  
7 physician.

8 3. A mammogram every year for a woman fifty years of age and over.

9 K. Any contract that is issued to the enrollee and that provides  
10 coverage for maternity benefits shall also provide that the maternity  
11 benefits apply to the costs of the birth of any child legally adopted by the  
12 enrollee if all the following are true:

13 1. The child is adopted within one year of birth.

14 2. The enrollee is legally obligated to pay the costs of birth.

15 3. All preexisting conditions and other limitations have been met and  
16 all deductibles and copayments have been paid by the enrollee.

17 4. The enrollee has notified the insurer of the enrollee's  
18 acceptability to adopt children pursuant to section 8-105 within sixty days  
19 after such approval or within sixty days after a change in insurance  
20 policies, plans or companies.

21 L. The coverage prescribed by subsection K of this section is excess  
22 to any other coverage the natural mother may have for maternity benefits  
23 except coverage made available to persons pursuant to title 36, chapter 29  
24 but not including coverage made available to persons defined as eligible  
25 under section 36-2901, paragraph 6, subdivisions (b), (c), (d) and (e). If  
26 such other coverage exists the agency, attorney or individual arranging the  
27 adoption shall make arrangements for the insurance to pay those costs that  
28 may be covered under that policy and shall advise the adopting parent in  
29 writing of the existence and extent of the coverage without disclosing any  
30 confidential information such as the identity of the natural parent. The  
31 enrollee adopting parents shall notify their health care services  
32 organization of the existence and extent of the other coverage. A health  
33 care services organization is not required to pay any costs in excess of the  
34 amounts it would have been obligated to pay to its hospitals and providers if  
35 the natural mother and child had received the maternity and newborn care  
36 directly from or through that health care services organization.

37 M. Each health care services organization shall offer membership to  
38 the following in a conversion plan that provides the basic health care  
39 benefits required by the director:

40 1. Each enrollee including the enrollee's enrolled dependents leaving  
41 a group.

42 2. Each enrollee and the enrollee's dependents who would otherwise  
43 cease to be eligible for membership because of the age of the enrollee or the  
44 enrollee's dependents or the death or the dissolution of marriage of an  
45 enrollee.

1           N. A health care services organization shall not cancel or nonrenew an  
2 evidence of coverage issued to an individual on a nongroup basis, including a  
3 conversion plan, except for any of the following reasons and in compliance  
4 with the notice and disclosure requirements contained in subsection H of this  
5 section:

6           1. The individual has failed to pay premiums or contributions in  
7 accordance with the terms of the evidence of coverage or the health care  
8 services organization has not received premium payments in a timely manner.

9           2. The individual has performed an act or practice that constitutes  
10 fraud or the individual made an intentional misrepresentation of material  
11 fact under the terms of the evidence of coverage.

12           3. The health care services organization has ceased to offer coverage  
13 to individuals that is consistent with the requirements of sections 20-1379  
14 and 20-1380.

15           4. If the health care services organization offers a health care plan  
16 in this state through a network plan, the individual no longer resides, lives  
17 or works in the service area served by the network plan or in an area for  
18 which the health care services organization is authorized to transact  
19 business but only if the coverage is terminated uniformly without regard to  
20 any health status-related factor of the covered individual.

21           5. If the health care services organization offers health coverage in  
22 this state in the individual market only through one or more bona fide  
23 associations, the membership of the individual in the association has ceased  
24 but only if that coverage is terminated uniformly without regard to any  
25 health status-related factor of any covered individual.

26           O. A conversion plan may be modified if the modification complies with  
27 the notice and disclosure provisions for cancellation and nonrenewal under  
28 subsection H of this section. A modification of a conversion plan that has  
29 already been issued shall not result in the effective elimination of any  
30 benefit originally included in the conversion plan.

31           P. Any person who is a United States armed forces reservist, who is  
32 ordered to active military duty on or after August 22, 1990 and who was  
33 enrolled in a health care plan shall have the right to reinstate such  
34 coverage upon release from active military duty subject to the following  
35 conditions:

36           1. The reservist shall make written application to the health plan  
37 within ninety days of discharge from active military duty or within one year  
38 of hospitalization continuing after discharge. Coverage shall be effective  
39 upon receipt of the application by the health plan.

40           2. The health plan may exclude from such coverage any health or  
41 physical condition arising during and occurring as a direct result of active  
42 military duty.

43           Q. The director shall adopt emergency rules applicable to persons who  
44 are leaving active service in the armed forces of the United States and

1 returning to civilian status consistent with ~~the provisions of~~ subsection P  
2 of this section including:

- 3 1. Conditions of eligibility.
- 4 2. Coverage of dependents.
- 5 3. Preexisting conditions.
- 6 4. Termination of insurance.
- 7 5. Probationary periods.
- 8 6. Limitations.
- 9 7. Exceptions.
- 10 8. Reductions.
- 11 9. Elimination periods.
- 12 10. Requirements for replacement.
- 13 11. Any other conditions of evidences of coverage.

14 R. Any contract that provides maternity benefits shall not restrict  
15 benefits for any hospital length of stay in connection with childbirth for  
16 the mother or the newborn child to less than forty-eight hours following a  
17 normal vaginal delivery or ninety-six hours following a cesarean section.  
18 The contract shall not require the provider to obtain authorization from the  
19 health care services organization for prescribing the minimum length of stay  
20 required by this subsection. The contract may provide that an attending  
21 provider in consultation with the mother may discharge the mother or the  
22 newborn child before the expiration of the minimum length of stay required by  
23 this subsection. The health care services organization shall not:

24 1. Deny the mother or the newborn child eligibility or continued  
25 eligibility to enroll or to renew coverage under the terms of the contract  
26 solely for the purpose of avoiding the requirements of this subsection.

27 2. Provide monetary payments or rebates to mothers to encourage those  
28 mothers to accept less than the minimum protections available pursuant to  
29 this subsection.

30 3. Penalize or otherwise reduce or limit the reimbursement of an  
31 attending provider because that provider provided care to any insured under  
32 the contract in accordance with this subsection.

33 4. Provide monetary or other incentives to an attending provider to  
34 induce that provider to provide care to an insured under the contract in a  
35 manner that is inconsistent with this subsection.

36 5. Except as described in subsection S of this section, restrict  
37 benefits for any portion of a period within the minimum length of stay in a  
38 manner that is less favorable than the benefits provided for any preceding  
39 portion of that stay.

40 S. Nothing in subsection R of this section:

41 1. Requires a mother to give birth in a hospital or to stay in the  
42 hospital for a fixed period of time following the birth of the child.

43 2. Prevents a health care services organization from imposing  
44 deductibles, coinsurance or other cost sharing in relation to benefits for  
45 hospital lengths of stay in connection with childbirth for a mother or a

newborn child under the contract, except that any coinsurance or other cost sharing for any portion of a period within a hospital length of stay required pursuant to subsection R of this section shall not be greater than the coinsurance or cost sharing for any preceding portion of that stay.

3. Prevents a health care services organization from negotiating the level and type of reimbursement with a provider for care provided in accordance with subsection R of this section.

T. Any contract or evidence of coverage that provides coverage for diabetes shall also provide coverage for equipment and supplies that are medically necessary and that are prescribed by a health care provider including:

1. Blood glucose monitors.
2. Blood glucose monitors for the legally blind.
3. Test strips for glucose monitors and visual reading and urine testing strips.
4. Insulin preparations and glucagon.
5. Insulin cartridges.
6. Drawing up devices and monitors for the visually impaired.
7. Injection aids.
8. Insulin cartridges for the legally blind.
9. Syringes and lancets including automatic lancing devices.
10. Prescribed oral agents for controlling blood sugar that are included on the plan formulary.
11. To the extent coverage is required under medicare, podiatric appliances for prevention of complications associated with diabetes.
12. Any other device, medication, equipment or supply for which coverage is required under medicare from and after January 1, 1999. The coverage required in this paragraph is effective six months after the coverage is required under medicare.

U. Nothing in subsection T of this section:

1. Entitles a member or enrollee of a health care services organization to equipment or supplies for the treatment of diabetes that are not medically necessary as determined by the health care services organization medical director or the medical director's designee.
2. Provides coverage for diabetic supplies obtained by a member or enrollee of a health care services organization without a prescription unless otherwise permitted pursuant to the terms of the health care plan.
3. Prohibits a health care services organization from imposing deductibles, coinsurance or other cost sharing in relation to benefits for equipment or supplies for the treatment of diabetes.

V. Any contract or evidence of coverage that provides coverage for prescription drugs shall not limit or exclude coverage for any prescription drug prescribed for the treatment of cancer on the basis that the prescription drug has not been approved by the United States food and drug administration for the treatment of the specific type of cancer for which the



1 prescription drug has been prescribed, if the prescription drug has been  
2 recognized as safe and effective for treatment of that specific type of  
3 cancer in one or more of the standard medical reference compendia prescribed  
4 in subsection W of this section or medical literature that meets the criteria  
5 prescribed in subsection W of this section. The coverage required under this  
6 subsection includes covered medically necessary services associated with the  
7 administration of the prescription drug. This subsection does not:

8 1. Require coverage of any prescription drug used in the treatment of  
9 a type of cancer if the United States food and drug administration has  
10 determined that the prescription drug is contraindicated for that type of  
11 cancer.

12 2. Require coverage for any experimental prescription drug that is not  
13 approved for any indication by the United States food and drug  
14 administration.

15 3. Alter any law with regard to provisions that limit the coverage of  
16 prescription drugs that have not been approved by the United States food and  
17 drug administration.

18 4. Notwithstanding section 20-1057.02, require reimbursement or  
19 coverage for any prescription drug that is not included in the drug formulary  
20 or list of covered prescription drugs specified in the contract or evidence  
21 of coverage.

22 5. Notwithstanding section 20-1057.02, prohibit a contract or evidence  
23 of coverage from limiting or excluding coverage of a prescription drug, if  
24 the decision to limit or exclude coverage of the prescription drug is not  
25 based primarily on the coverage of prescription drugs required by this  
26 section.

27 6. Prohibit the use of deductibles, coinsurance, copayments or other  
28 cost sharing in relation to drug benefits and related medical benefits  
29 offered.

30 W. For the purposes of subsection V of this section:

31 1. The acceptable standard medical reference compendia are the  
32 following:

33 (a) The American medical association drug evaluations, a publication  
34 of the American medical association.

35 (b) The American hospital formulary service drug information, a  
36 publication of the American society of health system pharmacists.

37 (c) Drug information for the health care provider, a publication of  
38 the United States pharmacopoeia convention.

39 2. Medical literature may be accepted if all of the following apply:

40 (a) At least two articles from major peer reviewed professional  
41 medical journals have recognized, based on scientific or medical criteria,  
42 the drug's safety and effectiveness for treatment of the indication for which  
43 the drug has been prescribed.

44 (b) No article from a major peer reviewed professional medical journal  
45 has concluded, based on scientific or medical criteria, that the drug is

1 unsafe or ineffective or that the drug's safety and effectiveness cannot be  
2 determined for the treatment of the indication for which the drug has been  
3 prescribed.

4 (c) The literature meets the uniform requirements for manuscripts  
5 submitted to biomedical journals established by the international committee  
6 of medical journal editors or is published in a journal specified by the  
7 United States department of health and human services as acceptable peer  
8 reviewed medical literature pursuant to section 186(t)(2)(B) of the social  
9 security act (42 United States Code section 1395x(t)(2)(B)).

10 X. A health care services organization shall not issue or deliver any  
11 advertising matter or sales material to any person in this state until the  
12 health care services organization files the advertising matter or sales  
13 material with the director. This subsection does not require a health care  
14 services organization to have the prior approval of the director to issue or  
15 deliver the advertising matter or sales material. If the director finds that  
16 the advertising matter or sales material, in whole or in part, is false,  
17 deceptive or misleading, the director may issue an order disapproving the  
18 advertising matter or sales material, directing the health care services  
19 organization to cease and desist from issuing, circulating, displaying or  
20 using the advertising matter or sales material within a period of time  
21 specified by the director but not less than ten days and imposing any  
22 penalties prescribed in this title. At least five days before issuing an  
23 order pursuant to this subsection, the director shall provide the health care  
24 services organization with a written notice of the basis of the order to  
25 provide the health care services organization with an opportunity to cure the  
26 alleged deficiency in the advertising matter or sales material within a  
27 single five day period for the particular advertising matter or sales  
28 material at issue. The health care services organization may appeal the  
29 director's order pursuant to title 41, chapter 6, article 10. Except as  
30 otherwise provided in this subsection, a health care services organization  
31 may obtain a stay of the effectiveness of the order as prescribed in section  
32 20-162. If the director certifies in the order and provides a detailed  
33 explanation of the reasons in support of the certification that continued use  
34 of the advertising matter or sales material poses a threat to the health,  
35 safety or welfare of the public, the order may be entered immediately without  
36 opportunity for cure and the effectiveness of the order is not stayed pending  
37 the hearing on the notice of appeal but the hearing shall be promptly  
38 instituted and determined.

39 Y. Any contract or evidence of coverage that is offered by a health  
40 care services organization and that contains a prescription drug benefit  
41 shall provide coverage of medical foods to treat inherited metabolic  
42 disorders OR MEDICALLY DIAGNOSED SEVERE ALLERGIC REACTIONS TO DIETARY  
43 COMPONENTS as provided by this section.

44 Z. The metabolic disorders OR ALLERGIC REACTIONS triggering medical  
45 foods coverage under this section shall:

1           1. Be part of the newborn screening program prescribed in section  
2 36-694 ~~OR BE DIAGNOSED SUBSEQUENT TO BIRTH.~~

3           2. Involve amino acid, carbohydrate or fat metabolism ~~OR SEVERE~~  
4 ~~ALLERGIC REACTIONS TO DIETARY COMPONENTS.~~

5           3. Have medically standard methods of diagnosis, treatment and  
6 monitoring including quantification of metabolites in blood, urine or spinal  
7 fluid or enzyme or DNA confirmation in tissues.

8           4. Require specially processed or treated medical foods that are  
9 generally available only under the supervision and direction of a physician  
10 who is licensed pursuant to title 32, chapter 13 or 17, that must be consumed  
11 throughout life and without which the person may suffer serious mental or  
12 physical impairment.

13           AA. Medical foods eligible for coverage under this section shall be  
14 prescribed or ordered under the supervision of a physician licensed pursuant  
15 to title 32, chapter 13 or 17 as medically necessary for the therapeutic  
16 treatment of an inherited metabolic disease ~~OR A MEDICALLY DIAGNOSED SEVERE~~  
17 ~~ALLERGIC REACTION TO DIETARY COMPONENTS.~~

18           BB. A health care services organization shall cover at least ~~fifty~~  
19 ~~SEVENTY-FIVE~~ per cent of the cost of medical foods prescribed to treat  
20 inherited metabolic disorders ~~OR ALLERGIC REACTIONS~~ and covered pursuant to  
21 this section. An organization may limit the maximum annual benefit for  
22 medical foods under this section to ~~five~~ ~~TWENTY~~ thousand dollars, which  
23 applies to the cost of all prescribed modified low protein foods and  
24 metabolic formula.

25           CC. Unless preempted under federal law or unless federal law imposes  
26 greater requirements than this section, this section applies to a provider  
27 sponsored health care services organization.

28           DD. For the purposes of:

29           1. This section:

30           (a) "Inherited metabolic disorder" means a disease caused by an  
31 inherited abnormality of body chemistry and includes a disease tested under  
32 the newborn screening program prescribed in section 36-694.

33           (b) "Medical foods" means modified low protein foods and metabolic  
34 formula.

35           (c) "Metabolic formula" means foods that are all of the following:

36           (i) Formulated to be consumed or administered enterally under the  
37 supervision of a physician who is licensed pursuant to title 32, chapter 13  
38 or 17.

39           (ii) Processed or formulated to be deficient in one or more of the  
40 nutrients present in typical foodstuffs.

41           (iii) Administered for the medical and nutritional management of a  
42 person who has limited capacity to metabolize foodstuffs or certain nutrients  
43 contained in the foodstuffs or who has other specific nutrient requirements  
44 as established by medical evaluation.

1 (iv) Essential to a person's optimal growth, health and metabolic  
2 homeostasis.

3 (d) "Modified low protein foods" means foods that are all of the  
4 following:

5 (i) Formulated to be consumed or administered enterally under the  
6 supervision of a physician who is licensed pursuant to title 32, chapter 13  
7 or 17.

8 (ii) Processed or formulated to contain less than one gram of protein  
9 per unit of serving, but does not include a natural food that is naturally  
10 low in protein.

11 (iii) Administered for the medical and nutritional management of a  
12 person who has limited capacity to metabolize foodstuffs or certain nutrients  
13 contained in the foodstuffs or who has other specific nutrient requirements  
14 as established by medical evaluation.

15 (iv) Essential to a person's optimal growth, health and metabolic  
16 homeostasis.

17 2. Subsection B of this section, "child", for purposes of initial  
18 coverage of an adopted child or a child placed for adoption but not for  
19 purposes of termination of coverage of such child, means a person under the  
20 age of eighteen years.

21 Sec. 3. Section 20-1342, Arizona Revised Statutes, is amended to read:  
22 20-1342. Scope and format of policy; definitions

23 A. A policy of disability insurance shall not be delivered or issued  
24 for delivery to any person in this state unless it otherwise complies with  
25 this title and complies with the following:

26 1. The entire money and other considerations shall be expressed in the  
27 policy.

28 2. The time when the insurance takes effect and terminates shall be  
29 expressed in the policy.

30 3. It shall purport to insure only one person, except that a policy  
31 may insure, originally or by subsequent amendment, on the application of the  
32 policyholder or the policyholder's spouse, any two or more eligible members  
33 of that family, including husband, wife, dependent children or any children  
34 under a specified age that does not exceed nineteen years and any other  
35 person dependent upon the policyholder. Any policy, except accidental death  
36 and dismemberment, applied for that provides family coverage shall **ALSO**  
37 **PROVIDE**, as to such coverage of family members, ~~also provide~~ that the  
38 benefits applicable for children shall be payable with respect to a newly  
39 born child of the insured from the instant of such child's birth, to a child  
40 adopted by the insured, regardless of the age at which the child was adopted,  
41 and to a child who has been placed for adoption with the insured and for whom  
42 the application and approval procedures for adoption pursuant to section  
43 8-105 or 8-108 have been completed to the same extent that such coverage  
44 applies to other members of the family. The coverage for newly born or  
45 adopted children or children placed for adoption shall include coverage of

1 injury or sickness including necessary care and treatment of medically  
2 diagnosed congenital defects and birth abnormalities. If payment of a  
3 specific premium is required to provide coverage for a child, the policy may  
4 require that notification of birth, adoption or adoption placement of the  
5 child and payment of the required premium must be furnished to the insurer  
6 within thirty-one days after the date of birth, adoption or adoption  
7 placement in order to have the coverage continue beyond the thirty-one day  
8 period.

9 4. The style, arrangement and overall appearance of the policy shall  
10 give no undue prominence to any portion of the text, and every printed  
11 portion of the text of the policy and of any endorsements or attached papers  
12 shall be plainly printed in light-faced type of a style in general use, the  
13 size of which shall be uniform and not less than ten point with a lower case  
14 unspaced alphabet length of not less than one hundred and twenty point.  
15 "Text" shall include all printed matter except the name and address of the  
16 insurer, name or title of the policy, the brief description, if any, and  
17 captions and subcaptions.

18 5. The exceptions and reductions of indemnity shall be set forth in  
19 the policy and, other than those contained in sections 20-1345 through  
20 20-1368, shall be printed and, at the insurer's option, either included with  
21 the benefit provision to which they apply or under an appropriate caption  
22 such as "exceptions", or "exceptions and reductions", except that if an  
23 exception or reduction specifically applies only to a particular benefit of  
24 the policy, a statement of such exception or reduction shall be included with  
25 the benefit provision to which it applies.

26 6. Each such form, including riders and endorsements, shall be  
27 identified by a form number in the lower left-hand corner of the first page.

28 7. The policy shall contain no provision purporting to make any  
29 portion of the charter, rules, constitution or bylaws of the insurer a part  
30 of the policy unless such portion is set forth in full in the policy, except  
31 in the case of the incorporation of, or reference to, a statement of rates or  
32 classification of risks, or short-rate table filed with the director.

33 8. Each contract shall be so written that the corporation shall pay  
34 benefits:

35 (a) For performance of any surgical service that is covered by the  
36 terms of such contract, regardless of the place of service.

37 (b) For any home health services that are performed by a licensed home  
38 health agency and that a physician has prescribed in lieu of hospital  
39 services, as defined by the director, providing the hospital services would  
40 have been covered.

41 (c) For any diagnostic service that a physician has performed outside  
42 a hospital in lieu of inpatient service, providing the inpatient service  
43 would have been covered.

(d) For any service performed in a hospital's outpatient department or in a freestanding surgical facility, providing such service would have been covered if performed as an inpatient service.

9. A disability insurance policy that provides coverage for the surgical expense of a mastectomy shall also provide coverage incidental to the patient's covered mastectomy for the expense of reconstructive surgery of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, prostheses, treatment of physical complications for all stages of the mastectomy, including lymphedemas, and at least two external postoperative prostheses subject to all of the terms and conditions of the policy.

10. A contract, except a supplemental contract covering a specified disease or other limited benefits, that provides coverage for surgical services for a mastectomy shall also provide coverage for mammography screening performed on dedicated equipment for diagnostic purposes on referral by a patient's physician, subject to all of the terms and conditions of the policy and according to the following guidelines:

(a) A baseline mammogram for a woman from age thirty-five to thirty-nine.

(b) A mammogram for a woman from age forty to forty-nine every two years or more frequently based on the recommendation of the woman's physician.

(c) A mammogram every year for a woman fifty years of age and over.

11. Any contract that is issued to the insured and that provides coverage for maternity benefits shall also provide that the maternity benefits apply to the costs of the birth of any child legally adopted by the insured if all the following are true:

(a) The child is adopted within one year of birth.

(b) The insured is legally obligated to pay the costs of birth.

(c) All preexisting conditions and other limitations have been met by the insured.

(d) The insured has notified the insurer of the insured's acceptability to adopt children pursuant to section 8-105, within sixty days after such approval or within sixty days after a change in insurance policies, plans or companies.

12. The coverage prescribed by paragraph 11 of this subsection is excess to any other coverage the natural mother may have for maternity benefits except coverage made available to persons pursuant to title 36, chapter 29, but not including coverage made available to persons defined as eligible under section 36-2901, paragraph 6, subdivisions (b), (c), (d) and (e). If such other coverage exists the agency, attorney or individual arranging the adoption shall make arrangements for the insurance to pay those costs that may be covered under that policy and shall advise the adopting parent in writing of the existence and extent of the coverage without disclosing any confidential information such as the identity of the natural

parent. The insured adopting parents shall notify their insurer of the existence and extent of the other coverage.

B. Any contract that provides maternity benefits shall not restrict benefits for any hospital length of stay in connection with childbirth for the mother or the newborn child to less than forty-eight hours following a normal vaginal delivery or ninety-six hours following a cesarean section. The contract shall not require the provider to obtain authorization from the insurer for prescribing the minimum length of stay required by this subsection. The contract may provide that an attending provider in consultation with the mother may discharge the mother or the newborn child before the expiration of the minimum length of stay required by this subsection. The insurer shall not:

1. Deny the mother or the newborn child eligibility or continued eligibility to enroll or to renew coverage under the terms of the contract solely for the purpose of avoiding the requirements of this subsection.

2. Provide monetary payments or rebates to mothers to encourage those mothers to accept less than the minimum protections available pursuant to this subsection.

3. Penalize or otherwise reduce or limit the reimbursement of an attending provider because that provider provided care to any insured under the contract in accordance with this subsection.

4. Provide monetary or other incentives to an attending provider to induce that provider to provide care to an insured under the contract in a manner that is inconsistent with this subsection.

5. Except as described in subsection C of this section, restrict benefits for any portion of a period within the minimum length of stay in a manner that is less favorable than the benefits provided for any preceding portion of that stay.

C. Nothing in subsection B of this section:

1. Requires a mother to give birth in a hospital or to stay in the hospital for a fixed period of time following the birth of the child.

2. Prevents an insurer from imposing deductibles, coinsurance or other cost sharing in relation to benefits for hospital lengths of stay in connection with childbirth for a mother or a newborn child under the contract, except that any coinsurance or other cost sharing for any portion of a period within a hospital length of stay required pursuant to subsection B of this section shall not be greater than the coinsurance or cost sharing for any preceding portion of that stay.

3. Prevents an insurer from negotiating the level and type of reimbursement with a provider for care provided in accordance with subsection B of this section.

D. Any contract that provides coverage for diabetes shall also provide coverage for equipment and supplies that are medically necessary and that are prescribed by a health care provider including:

1. Blood glucose monitors.

- 1           2. Blood glucose monitors for the legally blind.
- 2           3. Test strips for glucose monitors and visual reading and urine
- 3 testing strips.
- 4           4. Insulin preparations and glucagon.
- 5           5. Insulin cartridges.
- 6           6. Drawing up devices and monitors for the visually impaired.
- 7           7. Injection aids.
- 8           8. Insulin cartridges for the legally blind.
- 9           9. Syringes and lancets including automatic lancing devices.
- 10          10. Prescribed oral agents for controlling blood sugar that are
- 11 included on the plan formulary.
- 12          11. To the extent coverage is required under medicare, podiatric
- 13 appliances for prevention of complications associated with diabetes.
- 14          12. Any other device, medication, equipment or supply for which
- 15 coverage is required under medicare from and after January 1, 1999. The
- 16 coverage required in this paragraph is effective six months after the
- 17 coverage is required under medicare.
- 18          E. Nothing in subsection D of this section:
- 19           1. Prohibits a disability insurer from imposing deductibles,
- 20 coinsurance or other cost sharing in relation to benefits for equipment or
- 21 supplies for the treatment of diabetes.
- 22           2. Requires a policy to provide an insured with outpatient benefits if
- 23 the policy does not cover outpatient benefits.
- 24          F. Any contract that provides coverage for prescription drugs shall
- 25 not limit or exclude coverage for any prescription drug prescribed for the
- 26 treatment of cancer on the basis that the prescription drug has not been
- 27 approved by the United States food and drug administration for the treatment
- 28 of the specific type of cancer for which the prescription drug has been
- 29 prescribed, if the prescription drug has been recognized as safe and
- 30 effective for treatment of that specific type of cancer in one or more of the
- 31 standard medical reference compendia prescribed in subsection G of this
- 32 section or medical literature that meets the criteria prescribed in
- 33 subsection G of this section. The coverage required under this subsection
- 34 includes covered medically necessary services associated with the
- 35 administration of the prescription drug. This subsection does not:
- 36           1. Require coverage of any prescription drug used in the treatment of
- 37 a type of cancer if the United States food and drug administration has
- 38 determined that the prescription drug is contraindicated for that type of
- 39 cancer.
- 40           2. Require coverage for any experimental prescription drug that is not
- 41 approved for any indication by the United States food and drug
- 42 administration.
- 43           3. Alter any law with regard to provisions that limit the coverage of
- 44 prescription drugs that have not been approved by the United States food and
- 45 drug administration.



4. Require reimbursement or coverage for any prescription drug that is not included in the drug formulary or list of covered prescription drugs specified in the contract.

5. Prohibit a contract from limiting or excluding coverage of a prescription drug, if the decision to limit or exclude coverage of the prescription drug is not based primarily on the coverage of prescription drugs required by this section.

6. Prohibit the use of deductibles, coinsurance, copayments or other cost sharing in relation to drug benefits and related medical benefits offered.

G. For the purposes of subsection F of this section:

1. The acceptable standard medical reference compendia are the following:

(a) The American medical association drug evaluations, a publication of the American medical association.

(b) The American hospital formulary service drug information, a publication of the American society of health system pharmacists.

(c) Drug information for the health care provider, a publication of the United States pharmacopoeia convention.

2. Medical literature may be accepted if all of the following apply:

(a) At least two articles from major peer reviewed professional medical journals have recognized, based on scientific or medical criteria, the drug's safety and effectiveness for treatment of the indication for which the drug has been prescribed.

(b) No article from a major peer reviewed professional medical journal has concluded, based on scientific or medical criteria, that the drug is unsafe or ineffective or that the drug's safety and effectiveness cannot be determined for the treatment of the indication for which the drug has been prescribed.

(c) The literature meets the uniform requirements for manuscripts submitted to biomedical journals established by the international committee of medical journal editors or is published in a journal specified by the United States department of health and human services as acceptable peer reviewed medical literature pursuant to section 186(t)(2)(B) of the social security act (42 United States Code section 1395x(t)(2)(B)).

H. Any contract that is offered by a disability insurer and that contains a routine outpatient prescription drug benefit shall provide coverage of medical foods to treat inherited metabolic disorders **OR MEDICALLY DIAGNOSED SEVERE ALLERGIC REACTIONS TO DIETARY COMPONENTS** as provided by this section.

I. The metabolic disorders **OR ALLERGIC REACTIONS** triggering medical foods coverage under this section shall:

1. Be part of the newborn screening program prescribed in section 36-694 **OR BE DIAGNOSED SUBSEQUENT TO BIRTH.**

2. Involve amino acid, carbohydrate or fat metabolism OR SEVERE ALLERGIC REACTIONS TO DIETARY COMPONENTS.

3. Have medically standard methods of diagnosis, treatment and monitoring including quantification of metabolites in blood, urine or spinal fluid or enzyme or DNA confirmation in tissues.

4. Require specially processed or treated medical foods that are generally available only under the supervision and direction of a physician who is licensed pursuant to title 32, chapter 13 or 17, that must be consumed throughout life and without which the person may suffer serious mental or physical impairment.

J. Medical foods eligible for coverage under this section shall be prescribed or ordered under the supervision of a physician licensed pursuant to title 32, chapter 13 or 17 as medically necessary for the therapeutic treatment of an inherited metabolic disease OR A MEDICALLY DIAGNOSED SEVERE ALLERGIC REACTION TO DIETARY COMPONENTS.

K. An insurer shall cover at least ~~fifty~~ SEVENTY-FIVE per cent of the cost of medical foods prescribed to treat inherited metabolic disorders OR ALLERGIC REACTIONS and covered pursuant to this section. An insurer may limit the maximum annual benefit for medical foods under this section to ~~five~~ TWENTY thousand dollars, which applies to the cost of all prescribed modified low protein foods and metabolic formula.

L. For the purposes of:

1. This section:

(a) "Inherited metabolic disorder" means a disease caused by an inherited abnormality of body chemistry and includes a disease tested under the newborn screening program prescribed in section 36-694.

(b) "Medical foods" means modified low protein foods and metabolic formula.

(c) "Metabolic formula" means foods that are all of the following:

(i) Formulated to be consumed or administered enterally under the supervision of a physician who is licensed pursuant to title 32, chapter 13 or 17.

(ii) Processed or formulated to be deficient in one or more of the nutrients present in typical foodstuffs.

(iii) Administered for the medical and nutritional management of a person who has limited capacity to metabolize foodstuffs or certain nutrients contained in the foodstuffs or who has other specific nutrient requirements as established by medical evaluation.

(iv) Essential to a person's optimal growth, health and metabolic homeostasis.

(d) "Modified low protein foods" means foods that are all of the following:

(i) Formulated to be consumed or administered enterally under the supervision of a physician who is licensed pursuant to title 32, chapter 13 or 17.

1 (ii) Processed or formulated to contain less than one gram of protein  
2 per unit of serving, but does not include a natural food that is naturally  
3 low in protein.

4 (iii) Administered for the medical and nutritional management of a  
5 person who has limited capacity to metabolize foodstuffs or certain nutrients  
6 contained in the foodstuffs or who has other specific nutrient requirements  
7 as established by medical evaluation.

8 (iv) Essential to a person's optimal growth, health and metabolic  
9 homeostasis.

10 2. Subsection A of this section, the term "child", for purposes of  
11 initial coverage of an adopted child or a child placed for adoption but not  
12 for purposes of termination of coverage of such child, means a person under  
13 the age of eighteen years.

14 Sec. 4. Section 20-1402, Arizona Revised Statutes, is amended to read:  
15 20-1402. Provisions of group disability policies; definitions

16 A. Each group disability policy shall contain in substance the  
17 following provisions:

18 1. A provision that, in the absence of fraud, all statements made by  
19 the policyholder or by any insured person shall be deemed representations and  
20 not warranties, and that no statement made for the purpose of effecting  
21 insurance shall avoid such insurance or reduce benefits unless contained in a  
22 written instrument signed by the policyholder or the insured person, a copy  
23 of which has been furnished to the policyholder or to the person or  
24 beneficiary.

25 2. A provision that the insurer will furnish to the policyholder, for  
26 delivery to each employee or member of the insured group, an individual  
27 certificate setting forth in summary form a statement of the essential  
28 features of the insurance coverage of the employee or member and to whom  
29 benefits are payable. If dependents or family members are included in the  
30 coverage, additional certificates need not be issued for delivery to the  
31 dependents or family members. Any policy, except accidental death and  
32 dismemberment, applied for that provides family coverage shall **ALSO PROVIDE**,  
33 as to such coverage of family members, ~~also provide~~ that the benefits  
34 applicable for children shall be payable with respect to a newly born child  
35 of the insured from the instant of such child's birth, to a child adopted by  
36 the insured, regardless of the age at which the child was adopted, and to a  
37 child who has been placed for adoption with the insured and for whom the  
38 application and approval procedures for adoption pursuant to section 8-105 or  
39 8-108 have been completed to the same extent that such coverage applies to  
40 other members of the family. The coverage for newly born or adopted children  
41 or children placed for adoption shall include coverage of injury or sickness  
42 including the necessary care and treatment of medically diagnosed congenital  
43 defects and birth abnormalities. If payment of a specific premium is  
44 required to provide coverage for a child, the policy may require that  
45 notification of birth, adoption or adoption placement of the child and

1 payment of the required premium must be furnished to the insurer within  
2 thirty-one days after the date of birth, adoption or adoption placement in  
3 order to have the coverage continue beyond such thirty-one day period.

4 3. A provision that to the group originally insured may be added from  
5 time to time eligible new employees or members or dependents, as the case may  
6 be, in accordance with the terms of the policy.

7 4. Each contract shall be so written that the corporation shall pay  
8 benefits:

9 (a) For performance of any surgical service that is covered by the  
10 terms of such contract, regardless of the place of service.

11 (b) For any home health services that are performed by a licensed home  
12 health agency and that a physician has prescribed in lieu of hospital  
13 services, as defined by the director, providing the hospital services would  
14 have been covered.

15 (c) For any diagnostic service that a physician has performed outside  
16 a hospital in lieu of inpatient service, providing the inpatient service  
17 would have been covered.

18 (d) For any service performed in a hospital's outpatient department or  
19 in a freestanding surgical facility, providing such service would have been  
20 covered if performed as an inpatient service.

21 5. A group disability insurance policy that provides coverage for the  
22 surgical expense of a mastectomy shall also provide coverage incidental to  
23 the patient's covered mastectomy for the expense of reconstructive surgery of  
24 the breast on which the mastectomy was performed, surgery and reconstruction  
25 of the other breast to produce a symmetrical appearance, prostheses,  
26 treatment of physical complications for all stages of the mastectomy,  
27 including lymphedemas, and at least two external postoperative prostheses  
28 subject to all of the terms and conditions of the policy.

29 6. A contract, except a supplemental contract covering a specified  
30 disease or other limited benefits, that provides coverage for surgical  
31 services for a mastectomy shall also provide coverage for mammography  
32 screening performed on dedicated equipment for diagnostic purposes on  
33 referral by a patient's physician, subject to all of the terms and conditions  
34 of the policy and according to the following guidelines:

35 (a) A baseline mammogram for a woman from age thirty-five to  
36 thirty-nine.

37 (b) A mammogram for a woman from age forty to forty-nine every two  
38 years or more frequently based on the recommendation of the woman's  
39 physician.

40 (c) A mammogram every year for a woman fifty years of age and over.

41 7. Any contract that is issued to the insured and that provides  
42 coverage for maternity benefits shall also provide that the maternity  
43 benefits apply to the costs of the birth of any child legally adopted by the  
44 insured if all the following are true:

45 (a) The child is adopted within one year of birth.

1 (b) The insured is legally obligated to pay the costs of birth.

2 (c) All preexisting conditions and other limitations have been met by  
3 the insured.

4 (d) The insured has notified the insurer of the insured's  
5 acceptability to adopt children pursuant to section 8-105, within sixty days  
6 after such approval or within sixty days after a change in insurance  
7 policies, plans or companies.

8 8. The coverage prescribed by paragraph 7 of this subsection is excess  
9 to any other coverage the natural mother may have for maternity benefits  
10 except coverage made available to persons pursuant to title 36, chapter 29,  
11 but not including coverage made available to persons defined as eligible  
12 under section 36-2901, paragraph 6, subdivisions (b), (c), (d) and (e). If  
13 such other coverage exists the agency, attorney or individual arranging the  
14 adoption shall make arrangements for the insurance to pay those costs that  
15 may be covered under that policy and shall advise the adopting parent in  
16 writing of the existence and extent of the coverage without disclosing any  
17 confidential information such as the identity of the natural parent. The  
18 insured adopting parents shall notify their insurer of the existence and  
19 extent of the other coverage.

20 B. Any policy that provides maternity benefits shall not restrict  
21 benefits for any hospital length of stay in connection with childbirth for  
22 the mother or the newborn child to less than forty-eight hours following a  
23 normal vaginal delivery or ninety-six hours following a cesarean  
24 section. The policy shall not require the provider to obtain authorization  
25 from the insurer for prescribing the minimum length of stay required by this  
26 subsection. The policy may provide that an attending provider in  
27 consultation with the mother may discharge the mother or the newborn child  
28 before the expiration of the minimum length of stay required by this  
29 subsection. The insurer shall not:

30 1. Deny the mother or the newborn child eligibility or continued  
31 eligibility to enroll or to renew coverage under the terms of the policy  
32 solely for the purpose of avoiding the requirements of this subsection.

33 2. Provide monetary payments or rebates to mothers to encourage those  
34 mothers to accept less than the minimum protections available pursuant to  
35 this subsection.

36 3. Penalize or otherwise reduce or limit the reimbursement of an  
37 attending provider because that provider provided care to any insured under  
38 the policy in accordance with this subsection.

39 4. Provide monetary or other incentives to an attending provider to  
40 induce that provider to provide care to an insured under the policy in a  
41 manner that is inconsistent with this subsection.

42 5. Except as described in subsection C of this section, restrict  
43 benefits for any portion of a period within the minimum length of stay in a  
44 manner that is less favorable than the benefits provided for any preceding  
45 portion of that stay.

1 C. Nothing in subsection B of this section:

2 1. Requires a mother to give birth in a hospital or to stay in the  
3 hospital for a fixed period of time following the birth of the child.

4 2. Prevents an insurer from imposing deductibles, coinsurance or other  
5 cost sharing in relation to benefits for hospital lengths of stay in  
6 connection with childbirth for a mother or a newborn child under the policy,  
7 except that any coinsurance or other cost sharing for any portion of a period  
8 within a hospital length of stay required pursuant to subsection B of this  
9 section shall not be greater than the coinsurance or cost sharing for any  
10 preceding portion of that stay.

11 3. Prevents an insurer from negotiating the level and type of  
12 reimbursement with a provider for care provided in accordance with  
13 subsection B of this section.

14 D. Any contract that provides coverage for diabetes shall also provide  
15 coverage for equipment and supplies that are medically necessary and that are  
16 prescribed by a health care provider including:

17 1. Blood glucose monitors.

18 2. Blood glucose monitors for the legally blind.

19 3. Test strips for glucose monitors and visual reading and urine  
20 testing strips.

21 4. Insulin preparations and glucagon.

22 5. Insulin cartridges.

23 6. Drawing up devices and monitors for the visually impaired.

24 7. Injection aids.

25 8. Insulin cartridges for the legally blind.

26 9. Syringes and lancets including automatic lancing devices.

27 10. Prescribed oral agents for controlling blood sugar that are  
28 included on the plan formulary.

29 11. To the extent coverage is required under medicare, podiatric  
30 appliances for prevention of complications associated with diabetes.

31 12. Any other device, medication, equipment or supply for which  
32 coverage is required under medicare from and after January 1, 1999. The  
33 coverage required in this paragraph is effective six months after the  
34 coverage is required under medicare.

35 E. Nothing in subsection D of this section prohibits a group  
36 disability insurer from imposing deductibles, coinsurance or other cost  
37 sharing in relation to benefits for equipment or supplies for the treatment  
38 of diabetes.

39 F. Any contract that provides coverage for prescription drugs shall  
40 not limit or exclude coverage for any prescription drug prescribed for the  
41 treatment of cancer on the basis that the prescription drug has not been  
42 approved by the United States food and drug administration for the treatment  
43 of the specific type of cancer for which the prescription drug has been  
44 prescribed, if the prescription drug has been recognized as safe and  
45 effective for treatment of that specific type of cancer in one or more of the

1 standard medical reference compendia prescribed in subsection G of this  
 2 section or medical literature that meets the criteria prescribed in  
 3 subsection G of this section. The coverage required under this subsection  
 4 includes covered medically necessary services associated with the  
 5 administration of the prescription drug. This subsection does not:

6 1. Require coverage of any prescription drug used in the treatment of  
 7 a type of cancer if the United States food and drug administration has  
 8 determined that the prescription drug is contraindicated for that type of  
 9 cancer.

10 2. Require coverage for any experimental prescription drug that is not  
 11 approved for any indication by the United States food and drug  
 12 administration.

13 3. Alter any law with regard to provisions that limit the coverage of  
 14 prescription drugs that have not been approved by the United States food and  
 15 drug administration.

16 4. Require reimbursement or coverage for any prescription drug that is  
 17 not included in the drug formulary or list of covered prescription drugs  
 18 specified in the contract.

19 5. Prohibit a contract from limiting or excluding coverage of a  
 20 prescription drug, if the decision to limit or exclude coverage of the  
 21 prescription drug is not based primarily on the coverage of prescription  
 22 drugs required by this section.

23 6. Prohibit the use of deductibles, coinsurance, copayments or other  
 24 cost sharing in relation to drug benefits and related medical benefits  
 25 offered.

26 G. For the purposes of subsection F of this section:

27 1. The acceptable standard medical reference compendia are the  
 28 following:

29 (a) The American medical association drug evaluations, a publication  
 30 of the American medical association.

31 (b) The American hospital formulary service drug information, a  
 32 publication of the American society of health system pharmacists.

33 (c) Drug information for the health care provider, a publication of  
 34 the United States pharmacopoeia convention.

35 2. Medical literature may be accepted if all of the following apply:

36 (a) At least two articles from major peer reviewed professional  
 37 medical journals have recognized, based on scientific or medical criteria,  
 38 the drug's safety and effectiveness for treatment of the indication for which  
 39 the drug has been prescribed.

40 (b) No article from a major peer reviewed professional medical journal  
 41 has concluded, based on scientific or medical criteria, that the drug is  
 42 unsafe or ineffective or that the drug's safety and effectiveness cannot be  
 43 determined for the treatment of the indication for which the drug has been  
 44 prescribed.

(c) The literature meets the uniform requirements for manuscripts submitted to biomedical journals established by the international committee of medical journal editors or is published in a journal specified by the United States department of health and human services as acceptable peer reviewed medical literature pursuant to section 186(t)(2)(B) of the social security act (42 United States Code section 1395x(t)(2)(B)).

H. Any contract that is offered by a group disability insurer and that contains a prescription drug benefit shall provide coverage of medical foods to treat inherited metabolic disorders **OR MEDICALLY DIAGNOSED SEVERE ALLERGIC REACTIONS TO DIETARY COMPONENTS** as provided by this section.

I. The metabolic disorders **OR ALLERGIC REACTIONS** triggering medical foods coverage under this section shall:

1. Be part of the newborn screening program prescribed in section 36-694 **OR BE DIAGNOSED SUBSEQUENT TO BIRTH.**

2. Involve amino acid, carbohydrate or fat metabolism **OR SEVERE ALLERGIC REACTIONS TO DIETARY COMPONENTS.**

3. Have medically standard methods of diagnosis, treatment and monitoring including quantification of metabolites in blood, urine or spinal fluid or enzyme or DNA confirmation in tissues.

4. Require specially processed or treated medical foods that are generally available only under the supervision and direction of a physician who is licensed pursuant to title 32, chapter 13 or 17, that must be consumed throughout life and without which the person may suffer serious mental or physical impairment.

J. Medical foods eligible for coverage under this section shall be prescribed or ordered under the supervision of a physician licensed pursuant to title 32, chapter 13 or 17 as medically necessary for the therapeutic treatment of an inherited metabolic disease **OR A MEDICALLY DIAGNOSED SEVERE ALLERGIC REACTION TO DIETARY COMPONENTS.**

K. An insurer shall cover at least ~~fifty~~ **SEVENTY-FIVE** per cent of the cost of medical foods prescribed to treat inherited metabolic disorders **OR ALLERGIC REACTIONS** and covered pursuant to this section. An insurer may limit the maximum annual benefit for medical foods under this section to ~~five~~ **TWENTY** thousand dollars, which applies to the cost of all prescribed modified low protein foods and metabolic formula.

L. Any group disability policy that provides coverage for:

1. Prescription drugs shall also provide coverage for any prescribed drug or device that is approved by the United States food and drug administration for use as a contraceptive. A group disability insurer may use a drug formulary, multitiered drug formulary or list but that formulary or list shall include oral, implant and injectable contraceptive drugs, intrauterine devices and prescription barrier methods if the group disability insurer does not impose deductibles, coinsurance, copayments or other cost containment measures for contraceptive drugs that are greater than the



1 deductibles, coinsurance, copayments or other cost containment measures for  
2 other drugs on the same level of the formulary or list.

3 2. Outpatient health care services shall also provide coverage for  
4 outpatient contraceptive services. For the purposes of this paragraph,  
5 "outpatient contraceptive services" means consultations, examinations,  
6 procedures and medical services provided on an outpatient basis and related  
7 to the use of **APPROVED** United States food and drug **ADMINISTRATION**  
8 prescription contraceptive methods to prevent unintended pregnancies.

9 M. Notwithstanding subsection L of this section, a religious employer  
10 whose religious tenets prohibit the use of prescribed contraceptive methods  
11 may require that the insurer provide a group disability policy without  
12 coverage for all ~~federal~~ **UNITED STATES** food and drug administration approved  
13 contraceptive methods. A religious employer shall submit a written affidavit  
14 to the insurer stating that it is a religious employer. On receipt of the  
15 affidavit, the insurer shall issue to the religious employer a group  
16 disability policy that excludes coverage of prescription contraceptive  
17 methods. The insurer shall retain the affidavit for the duration of the  
18 group disability policy and any renewals of the policy. Before a policy is  
19 issued, every religious employer that invokes this exemption shall provide  
20 prospective insureds written notice that the religious employer refuses to  
21 cover all ~~federal~~ **UNITED STATES** food and drug administration approved  
22 contraceptive methods for religious reasons. This subsection shall not  
23 exclude coverage for prescription contraceptive methods ordered by a health  
24 care provider with prescriptive authority for medical indications other than  
25 to prevent an unintended pregnancy. An insurer may require the insured to  
26 first pay for the prescription and then submit a claim to the insurer along  
27 with evidence that the prescription is for a noncontraceptive purpose. An  
28 insurer may charge an administrative fee for handling these claims. A  
29 religious employer shall not discriminate against an employee who  
30 independently chooses to obtain insurance coverage or prescriptions for  
31 contraceptives from another source.

32 N. For the purposes of:

33 1. This section:

34 (a) "Inherited metabolic disorder" means a disease caused by an  
35 inherited abnormality of body chemistry and includes a disease tested under  
36 the newborn screening program prescribed in section 36-694.

37 (b) "Medical foods" means modified low protein foods and metabolic  
38 formula.

39 (c) "Metabolic formula" means foods that are all of the following:

40 (i) Formulated to be consumed or administered enterally under the  
41 supervision of a physician who is licensed pursuant to title 32, chapter 13  
42 or 17.

43 (ii) Processed or formulated to be deficient in one or more of the  
44 nutrients present in typical foodstuffs.

1 (iii) Administered for the medical and nutritional management of a  
2 person who has limited capacity to metabolize foodstuffs or certain nutrients  
3 contained in the foodstuffs or who has other specific nutrient requirements  
4 as established by medical evaluation.

5 (iv) Essential to a person's optimal growth, health and metabolic  
6 homeostasis.

7 (d) "Modified low protein foods" means foods that are all of the  
8 following:

9 (i) Formulated to be consumed or administered enterally under the  
10 supervision of a physician who is licensed pursuant to title 32, chapter 13  
11 or 17.

12 (ii) Processed or formulated to contain less than one gram of protein  
13 per unit of serving, but does not include a natural food that is naturally  
14 low in protein.

15 (iii) Administered for the medical and nutritional management of a  
16 person who has limited capacity to metabolize foodstuffs or certain nutrients  
17 contained in the foodstuffs or who has other specific nutrient requirements  
18 as established by medical evaluation.

19 (iv) Essential to a person's optimal growth, health and metabolic  
20 homeostasis.

21 2. Subsection A of this section, the term "child", for purposes of  
22 initial coverage of an adopted child or a child placed for adoption but not  
23 for purposes of termination of coverage of such child, means a person under  
24 the age of eighteen years.

25 3. Subsection M of this section, "religious employer" means an entity  
26 for which all of the following apply:

27 (a) The entity primarily employs persons who share the religious  
28 tenets of the entity.

29 (b) The entity serves primarily persons who share the religious tenets  
30 of the entity.

31 (c) The entity is a nonprofit organization as described in section  
32 6033(a)(2)(A)(i) or (iii) of the internal revenue code of 1986, as amended.

33 Sec. 5. Section 20-1404, Arizona Revised Statutes, is amended to read:  
34 20-1404. Blanket disability insurance; definitions

35 A. Blanket disability insurance is that form of disability insurance  
36 covering special groups of persons as enumerated in one of the following  
37 paragraphs:

38 1. Under a policy or contract issued to any common carrier, which  
39 shall be deemed the policyholder, covering a group defined as all persons who  
40 may become passengers on such common carrier.

41 2. Under a policy or contract issued to an employer, who shall be  
42 deemed the policyholder, covering all employees or any group of employees  
43 defined by reference to exceptional hazards incident to such employment.  
44 Dependents of the employees and guests of the employer may also be included  
45 where exposed to the same hazards.

3. Under a policy or contract issued to a college, school or other institution of learning or to the head or principal thereof, who or which shall be deemed the policyholder, covering students or teachers.

4. Under a policy or contract issued in the name of any volunteer fire department or first aid or other such volunteer group, or agency having jurisdiction thereof, which shall be deemed the policyholder, covering all of the members of such fire department or group.

5. Under a policy or contract issued to a creditor, who shall be deemed the policyholder, to insure debtors of the creditor.

6. Under a policy or contract issued to a sports team or to a camp or sponsor thereof, which team or camp or sponsor thereof shall be deemed the policyholder, covering members or campers.

7. Under a policy or contract that is issued to any other substantially similar group and that, in the discretion of the director, may be subject to the issuance of a blanket disability policy or contract.

B. An individual application need not be required from a person covered under a blanket disability policy or contract, nor shall it be necessary for the insurer to furnish each person with a certificate.

C. All benefits under any blanket disability policy shall be payable to the person insured, or to the insured's designated beneficiary or beneficiaries, or to the insured's estate, except that if the person insured is a minor, such benefits may be made payable to the insured's parent or guardian or any other person actually supporting the insured, and except that the policy may provide that all or any portion of any indemnities provided by any such policy on account of hospital, nursing, medical or surgical services may, at the insurer's option, MAY be paid directly to the hospital or person rendering such services, but the policy may not require that the service be rendered by a particular hospital or person. Payment so made shall discharge the insurer's obligation with respect to the amount of insurance so paid.

D. Nothing contained in this section shall be deemed to affect the legal liability of policyholders for the death of or injury to any member of the group.

E. Any policy or contract, except accidental death and dismemberment, applied for that provides family coverage shall **ALSO PROVIDE**, as to such coverage of family members, ~~also provide~~ that the benefits applicable for children shall be payable with respect to a newly born child of the insured from the instant of such child's birth, to a child adopted by the insured, regardless of the age at which the child was adopted, and to a child who has been placed for adoption with the insured and for whom the application and approval procedures for adoption pursuant to section 8-105 or 8-108 have been completed to the same extent that such coverage applies to other members of the family. The coverage for newly born or adopted children or children placed for adoption shall include coverage of injury or sickness, including necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. If payment of a specific premium is required to provide

1 coverage for a child, the policy or contract may require that notification of  
2 birth, adoption or adoption placement of the child and payment of the  
3 required premium must be furnished to the insurer within thirty-one days  
4 after the date of birth, adoption or adoption placement in order to have the  
5 coverage continue beyond the thirty-one day period.

6 F. Each policy or contract shall be so written that the insurer shall  
7 pay benefits:

8 1. For performance of any surgical service that is covered by the  
9 terms of such contract, regardless of the place of service.

10 2. For any home health services that are performed by a licensed home  
11 health agency and that a physician has prescribed in lieu of hospital  
12 services, as defined by the director, providing the hospital services would  
13 have been covered.

14 3. For any diagnostic service that a physician has performed outside a  
15 hospital in lieu of inpatient service, providing the inpatient service would  
16 have been covered.

17 4. For any service performed in a hospital's outpatient department or  
18 in a freestanding surgical facility, providing such service would have been  
19 covered if performed as an inpatient service.

20 G. A blanket disability insurance policy that provides coverage for  
21 the surgical expense of a mastectomy shall also provide coverage incidental  
22 to the patient's covered mastectomy for the expense of reconstructive surgery  
23 of the breast on which the mastectomy was performed, surgery and  
24 reconstruction of the other breast to produce a symmetrical appearance,  
25 prostheses, treatment of physical complications for all stages of the  
26 mastectomy, including lymphedemas, and at least two external postoperative  
27 prostheses subject to all of the terms and conditions of the policy.

28 H. A contract that provides coverage for surgical services for a  
29 mastectomy shall also provide coverage for mammography screening performed on  
30 dedicated equipment for diagnostic purposes on referral by a patient's  
31 physician, subject to all of the terms and conditions of the policy and  
32 according to the following guidelines:

33 1. A baseline mammogram for a woman from age thirty-five to  
34 thirty-nine.

35 2. A mammogram for a woman from age forty to forty-nine every two  
36 years or more frequently based on the recommendation of the woman's  
37 physician.

38 3. A mammogram every year for a woman fifty years of age and over.

39 I. Any contract that is issued to the insured and that provides  
40 coverage for maternity benefits shall also provide that the maternity  
41 benefits apply to the costs of the birth of any child legally adopted by the  
42 insured if all the following are true:

43 1. The child is adopted within one year of birth.

44 2. The insured is legally obligated to pay the costs of birth.

1           3. All preexisting conditions and other limitations have been met by  
2 the insured.

3           4. The insured has notified the insurer of his acceptability to adopt  
4 children pursuant to section 8-105, within sixty days after such approval or  
5 within sixty days after a change in insurance policies, plans or companies.

6           J. The coverage prescribed by subsection I of this section is excess  
7 to any other coverage the natural mother may have for maternity benefits  
8 except coverage made available to persons pursuant to title 36, chapter 29,  
9 but not including coverage made available to persons defined as eligible  
10 under section 36-2901, paragraph 6, subdivisions (b), (c), (d) and (e). If  
11 such other coverage exists, the agency, attorney or individual arranging the  
12 adoption shall make arrangements for the insurance to pay those costs that  
13 may be covered under that policy and shall advise the adopting parent in  
14 writing of the existence and extent of the coverage without disclosing any  
15 confidential information such as the identity of the natural parent. The  
16 insured adopting parents shall notify their insurer of the existence and  
17 extent of the other coverage.

18           K. Any contract that provides maternity benefits shall not restrict  
19 benefits for any hospital length of stay in connection with childbirth for  
20 the mother or the newborn child to less than forty-eight hours following a  
21 normal vaginal delivery or ninety-six hours following a cesarean section. The  
22 contract shall not require the provider to obtain authorization from the  
23 insurer for prescribing the minimum length of stay required by this  
24 subsection. The contract may provide that an attending provider in  
25 consultation with the mother may discharge the mother or the newborn child  
26 before the expiration of the minimum length of stay required by this  
27 subsection. The insurer shall not:

28           1. Deny the mother or the newborn child eligibility or continued  
29 eligibility to enroll or to renew coverage under the terms of the contract  
30 solely for the purpose of avoiding the requirements of this subsection.

31           2. Provide monetary payments or rebates to mothers to encourage those  
32 mothers to accept less than the minimum protections available pursuant to  
33 this subsection.

34           3. Penalize or otherwise reduce or limit the reimbursement of an  
35 attending provider because that provider provided care to any insured under  
36 the contract in accordance with this subsection.

37           4. Provide monetary or other incentives to an attending provider to  
38 induce that provider to provide care to an insured under the contract in a  
39 manner that is inconsistent with this subsection.

40           5. Except as described in subsection L of this section, restrict  
41 benefits for any portion of a period within the minimum length of stay in a  
42 manner that is less favorable than the benefits provided for any preceding  
43 portion of that stay.

44           L. Nothing in subsection K of this section:

1           1. Requires a mother to give birth in a hospital or to stay in the  
2 hospital for a fixed period of time following the birth of the child.

3           2. Prevents an insurer from imposing deductibles, coinsurance or other  
4 cost sharing in relation to benefits for hospital lengths of stay in  
5 connection with childbirth for a mother or a newborn child under the  
6 contract, except that any coinsurance or other cost sharing for any portion  
7 of a period within a hospital length of stay required pursuant to subsection  
8 K of this section shall not be greater than the coinsurance or cost sharing  
9 for any preceding portion of that stay.

10          3. Prevents an insurer from negotiating the level and type of  
11 reimbursement with a provider for care provided in accordance with subsection  
12 K of this section.

13          M. Any contract that provides coverage for diabetes shall also provide  
14 coverage for equipment and supplies that are medically necessary and that are  
15 prescribed by a health care provider, including:

- 16           1. Blood glucose monitors.
- 17           2. Blood glucose monitors for the legally blind.
- 18           3. Test strips for glucose monitors and visual reading and urine  
19 testing strips.
- 20           4. Insulin preparations and glucagon.
- 21           5. Insulin cartridges.
- 22           6. Drawing up devices and monitors for the visually impaired.
- 23           7. Injection aids.
- 24           8. Insulin cartridges for the legally blind.
- 25           9. Syringes and lancets including automatic lancing devices.
- 26           10. Prescribed oral agents for controlling blood sugar that are  
27 included on the plan formulary.
- 28           11. To the extent coverage is required under medicare, podiatric  
29 appliances for prevention of complications associated with diabetes.
- 30           12. Any other device, medication, equipment or supply for which  
31 coverage is required under medicare from and after January 1, 1999. The  
32 coverage required in this paragraph is effective six months after the  
33 coverage is required under medicare.

34          N. Nothing in subsection M of this section prohibits a blanket  
35 disability insurer from imposing deductibles, coinsurance or other cost  
36 sharing in relation to benefits for equipment or supplies for the treatment  
37 of diabetes.

38          O. Any contract that provides coverage for prescription drugs shall  
39 not limit or exclude coverage for any prescription drug prescribed for the  
40 treatment of cancer on the basis that the prescription drug has not been  
41 approved by the United States food and drug administration for the treatment  
42 of the specific type of cancer for which the prescription drug has been  
43 prescribed, if the prescription drug has been recognized as safe and  
44 effective for treatment of that specific type of cancer in one or more of the  
45 standard medical reference compendia prescribed in subsection P of this

section or medical literature that meets the criteria prescribed in subsection P of this section. The coverage required under this subsection includes covered medically necessary services associated with the administration of the prescription drug. This subsection does not:

1. Require coverage of any prescription drug used in the treatment of a type of cancer if the United States food and drug administration has determined that the prescription drug is contraindicated for that type of cancer.

2. Require coverage for any experimental prescription drug that is not approved for any indication by the United States food and drug administration.

3. Alter any law with regard to provisions that limit the coverage of prescription drugs that have not been approved by the United States food and drug administration.

4. Require reimbursement or coverage for any prescription drug that is not included in the drug formulary or list of covered prescription drugs specified in the contract.

5. Prohibit a contract from limiting or excluding coverage of a prescription drug, if the decision to limit or exclude coverage of the prescription drug is not based primarily on the coverage of prescription drugs required by this section.

6. Prohibit the use of deductibles, coinsurance, copayments or other cost sharing in relation to drug benefits and related medical benefits offered.

P. For the purposes of subsection O of this section:

1. The acceptable standard medical reference compendia are the following:

(a) The American medical association drug evaluations, a publication of the American medical association.

(b) The American hospital formulary service drug information, a publication of the American society of health system pharmacists.

(c) Drug information for the health care provider, a publication of the United States pharmacopoeia convention.

2. Medical literature may be accepted if all of the following apply:

(a) At least two articles from major peer reviewed professional medical journals have recognized, based on scientific or medical criteria, the drug's safety and effectiveness for treatment of the indication for which the drug has been prescribed.

(b) No article from a major peer reviewed professional medical journal has concluded, based on scientific or medical criteria, that the drug is unsafe or ineffective or that the drug's safety and effectiveness cannot be determined for the treatment of the indication for which the drug has been prescribed.

(c) The literature meets the uniform requirements for manuscripts submitted to biomedical journals established by the international committee

1 of medical journal editors or is published in a journal specified by the  
 2 United States department of health and human services as acceptable peer  
 3 reviewed medical literature pursuant to section 186(t)(2)(B) of the social  
 4 security act (42 United States Code section 1395x(t)(2)(B)).

5 Q. Any contract that is offered by a blanket disability insurer and  
 6 that contains a prescription drug benefit shall provide coverage of medical  
 7 foods to treat inherited metabolic disorders OR MEDICALLY DIAGNOSED SEVERE  
 8 ALLERGIC REACTIONS TO DIETARY COMPONENTS as provided by this section.

9 R. The metabolic disorders OR ALLERGIC REACTIONS triggering medical  
 10 foods coverage under this section shall:

11 1. Be part of the newborn screening program prescribed in section  
 12 36-694 OR BE DIAGNOSED SUBSEQUENT TO BIRTH.

13 2. Involve amino acid, carbohydrate or fat metabolism OR SEVERE  
 14 ALLERGIC REACTIONS TO DIETARY COMPONENTS.

15 3. Have medically standard methods of diagnosis, treatment and  
 16 monitoring including quantification of metabolites in blood, urine or spinal  
 17 fluid or enzyme or DNA confirmation in tissues.

18 4. Require specially processed or treated medical foods that are  
 19 generally available only under the supervision and direction of a physician  
 20 who is licensed pursuant to title 32, chapter 13 or 17, that must be consumed  
 21 throughout life and without which the person may suffer serious mental or  
 22 physical impairment.

23 S. Medical foods eligible for coverage under this section shall be  
 24 prescribed or ordered under the supervision of a physician licensed pursuant  
 25 to title 32, chapter 13 or 17 as medically necessary for the therapeutic  
 26 treatment of an inherited metabolic disease OR A MEDICALLY DIAGNOSED SEVERE  
 27 ALLERGIC REACTION TO DIETARY COMPONENTS.

28 T. An insurer shall cover at least ~~fifty~~ SEVENTY-FIVE per cent of the  
 29 cost of medical foods prescribed to treat inherited metabolic disorders OR  
 30 ALLERGIC REACTIONS and covered pursuant to this section. An insurer may  
 31 limit the maximum annual benefit for medical foods under this section to ~~five~~  
 32 TWENTY thousand dollars which applies to the cost of all prescribed modified  
 33 low protein foods and metabolic formula.

34 U. Any blanket disability policy that provides coverage for:

35 1. Prescription drugs shall also provide coverage for any prescribed  
 36 drug or device that is approved by the United States food and drug  
 37 administration for use as a contraceptive. A blanket disability insurer may  
 38 use a drug formulary, multitiered drug formulary or list but that formulary  
 39 or list shall include oral, implant and injectable contraceptive drugs,  
 40 intrauterine devices and prescription barrier methods if the blanket  
 41 disability insurer does not impose deductibles, coinsurance, copayments or  
 42 other cost containment measures for contraceptive drugs that are greater than  
 43 the deductibles, coinsurance, copayments or other cost containment measures  
 44 for other drugs on the same level of the formulary or list.



2. Outpatient health care services shall also provide coverage for outpatient contraceptive services. For the purposes of this paragraph, "outpatient contraceptive services" means consultations, examinations, procedures and medical services provided on an outpatient basis and related to the use of ~~APPROVED~~ United States food and drug ~~ADMINISTRATION~~ prescription contraceptive methods to prevent unintended pregnancies.

V. Notwithstanding subsection U of this section, a religious employer whose religious tenets prohibit the use of prescribed contraceptive methods may require that the insurer provide a blanket disability policy without coverage for all ~~federal~~ UNITED STATES food and drug administration approved contraceptive methods. A religious employer shall submit a written affidavit to the insurer stating that it is a religious employer. On receipt of the affidavit, the insurer shall issue to the religious employer a blanket disability policy that excludes coverage of prescription contraceptive methods. The insurer shall retain the affidavit for the duration of the blanket disability policy and any renewals of the policy. Before a policy is issued, every religious employer that invokes this exemption shall provide prospective insureds written notice that the religious employer refuses to cover all ~~federal~~ UNITED STATES food and drug administration approved contraceptive methods for religious reasons. This subsection shall not exclude coverage for prescription contraceptive methods ordered by a health care provider with prescriptive authority for medical indications other than to prevent an unintended pregnancy. An insurer may require the insured to first pay for the prescription and then submit a claim to the insurer along with evidence that the prescription is for a noncontraceptive purpose. An insurer may charge an administrative fee for handling these claims under this ~~paragraph~~ SUBSECTION. A religious employer shall not discriminate against an employee who independently chooses to obtain insurance coverage or prescriptions for contraceptives from another source.

W. For the purposes of:

1. This section:

(a) "Inherited metabolic disorder" means a disease caused by an inherited abnormality of body chemistry and includes a disease tested under the newborn screening program prescribed in section 36-694.

(b) "Medical foods" means modified low protein foods and metabolic formula.

(c) "Metabolic formula" means foods that are all of the following:

(i) Formulated to be consumed or administered enterally under the supervision of a physician who is licensed pursuant to title 32, chapter 13 or 17.

(ii) Processed or formulated to be deficient in one or more of the nutrients present in typical foodstuffs.

(iii) Administered for the medical and nutritional management of a person who has limited capacity to metabolize foodstuffs or certain nutrients

1 contained in the foodstuffs or who has other specific nutrient requirements  
2 as established by medical evaluation.

3 (iv) Essential to a person's optimal growth, health and metabolic  
4 homeostasis.

5 (d) "Modified low protein foods" means foods that are all of the  
6 following:

7 (i) Formulated to be consumed or administered enterally under the  
8 supervision of a physician who is licensed pursuant to title 32, chapter 13  
9 or 17.

10 (ii) Processed or formulated to contain less than one gram of protein  
11 per unit of serving, but does not include a natural food that is naturally  
12 low in protein.

13 (iii) Administered for the medical and nutritional management of a  
14 person who has limited capacity to metabolize foodstuffs or certain nutrients  
15 contained in the foodstuffs or who has other specific nutrient requirements  
16 as established by medical evaluation.

17 (iv) Essential to a person's optimal growth, health and metabolic  
18 homeostasis.

19 2. Subsection E of this section, the term "child", for purposes of  
20 initial coverage of an adopted child or a child placed for adoption but not  
21 for purposes of termination of coverage of such child, means a person under  
22 the age of eighteen years.

23 3. Subsection V of this section, "religious employer" means an entity  
24 for which all of the following apply:

25 (a) The entity primarily employs persons who share the religious  
26 tenets of the entity.

27 (b) The entity serves primarily persons who share the religious tenets  
28 of the entity.

29 (c) The entity is a nonprofit organization as described in section  
30 6033(a)(2)(A)(i) or (iii) of the internal revenue code of 1986, as amended.

31 Sec. 6. Section 20-2327, Arizona Revised Statutes, is amended to read:  
32 20-2327. Metabolic disorders; medical foods; definitions

33 A. Any health benefits plan THAT IS offered by an accountable health  
34 plan AND that contains a prescription drug benefit shall provide coverage of  
35 medical foods to treat inherited metabolic disorders OR MEDICALLY DIAGNOSED  
36 SEVERE ALLERGIC REACTIONS TO DIETARY COMPONENTS as provided by this section.

37 B. The metabolic disorders OR ALLERGIC REACTIONS triggering medical  
38 foods coverage under this section shall:

39 1. Be part of the newborn screening program prescribed in section  
40 36-694 OR BE DIAGNOSED SUBSEQUENT TO BIRTH.

41 2. Involve amino acid, carbohydrate or fat metabolism OR SEVERE  
42 ALLERGIC REACTIONS TO DIETARY COMPONENTS.

43 3. Have medically standard methods of diagnosis, treatment and  
44 monitoring including quantification of metabolites in blood, urine or spinal  
45 fluid or enzyme or DNA confirmation in tissues.

4. Require specially processed or treated medical foods that are generally available only under the supervision and direction of a physician who is licensed pursuant to title 32, chapter 13 or 17, that must be consumed throughout life and without which the person may suffer serious mental or physical impairment.

C. Medical foods eligible for coverage under this section shall be prescribed or ordered under the supervision of a physician licensed pursuant to title 32, chapter 13 or 17 as medically necessary for the therapeutic treatment of an inherited metabolic disease OR A MEDICALLY DIAGNOSED SEVERE ALLERGIC REACTION TO DIETARY COMPONENTS.

D. An accountable health plan shall cover at least ~~fifty~~ SEVENTY-FIVE per cent of the cost of medical foods prescribed to treat inherited metabolic disorders OR ALLERGIC REACTIONS and covered pursuant to this section. A ~~corporation~~ PLAN may limit the maximum annual benefit for medical foods under this section to ~~five~~ TWENTY thousand dollars which applies to the cost of all prescribed modified low protein foods and metabolic formula.

E. For the purposes of this section:

1. "Inherited metabolic disorder" means a disease caused by an inherited abnormality of body chemistry and includes a disease tested under the newborn screening program prescribed in section 36-694.

2. "Medical foods" means modified low protein foods and metabolic formula.

3. "Metabolic formula" means foods that are all of the following:

(a) Formulated to be consumed or administered enterally under the supervision of a physician who is licensed pursuant to title 32, chapter 13 or 17.

(b) Processed or formulated to be deficient in one or more of the nutrients present in typical foodstuffs.

(c) Administered for the medical and nutritional management of a person who has limited capacity to metabolize foodstuffs or certain nutrients contained in the foodstuffs or who has other specific nutrient requirements as established by medical evaluation.

(d) Essential to a person's optimal growth, health and metabolic homeostasis.

4. "Modified low protein foods" means foods that are all of the following:

(a) Formulated to be consumed or administered enterally under the supervision of a physician who is licensed pursuant to title 32, chapter 13 or 17.

(b) Processed or formulated to contain less than one gram of protein per unit of serving, but does not include a natural food that is naturally low in protein.

- 1           (c) Administered for the medical and nutritional management of a
- 2 person who has limited capacity to metabolize foodstuffs or certain nutrients
- 3 contained in the foodstuffs or who has other specific nutrient requirements
- 4 as established by medical evaluation.
- 5           (d) Essential to a person's optimal growth, health and metabolic
- 6 homeostasis.